



Housing Options Project for People with a Mental Illness

'When you get ill and sick it's very hard to concentrate on what you are doing, and what help is needed.' Consumer

PROJECT FUNDING

The Housing Options Project was funded by the Commonwealth Department of Family and Community Services under the National Homelessness Strategy

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1. EXECUTIVE SUMMARY

This report documents the findings of the Housing Options Project (HOP) an action research study designed to explore the issues around mental health and homelessness and to provide direct support services for a group of inpatients in the Cowdy Ward of the Northern Territory's Royal Darwin Hospital (RDH).

The HOP, funded through the Commonwealth Department of Family and Community Services and managed by Top End Association of Mental Health (TEAM Health), sought to address the following objectives:

- To provide practical support within a case management framework to clients with a mental illness who had been admitted to RDH and who were homeless on admission or at risk of homelessness on discharge;
- To develop and document strategies which promoted positive outcomes for people at risk of homelessness who had a mental illness;
- To identify issues and undertake systems advocacy to raise awareness and promote change that would improve access to a range of services that supported people with a mental illness to secure and maintain stable housing;
- To promote collaboration between the Top End Mental Health Service (TEMHS), other relevant agencies and TEAM Health, to promote positive housing and housing related outcomes for people with a mental illness; and
- To document service delivery strategies and policy changes that had been trialled and to develop a good practice guide to inform future policy and practice at a national level.

Outcomes and Findings

The project surveyed some 261 clients including 130 indigenous clients. The project provided direct support to 26 clients. This support covered a range of assistance including access to other services, transport, advocacy, information and referral. Clients who provided feedback on this support indicated a high level of satisfaction.

The project's client group is predominantly male, aged between 20 and 34, with a diagnosed affective disorder or schizophrenia and drug/alcohol abuse issues and in receipt of Centrelink income support.

The Project found that positive housing outcomes for clients in Darwin are dependent on a range of factors. These are:

- Collaboration between services, particularly between TEMHS, TEAM Health, Centrelink and supported accommodation services;
- Choice in housing options including freedom from discrimination;

- Accessibility to a range of housing options ranging from high support to low support including landlord use of the Centrepay system;
- Provision of psychiatric disability supported accommodation;
- Flexibility of disability support service delivery which promotes sensitivity to variations in client need, resilience in client's capacity to manage life events, patterns of occurrence of illness;
- Provision of disability support to access housing and other services while an inpatient of Cowdy Ward;
- Provision of disability support post discharge to assist clients to manage the broad range of social, family, vocational and employment, psychological and environmental issues in their lives;
- Size of caseload is best determined by an assessment of the complex needs of each client and that it is not useful to set a figure.

Recommendations

The following recommendations are made as a result of the research:

- 1) That TEAM Health liaise with Top End Mental Health Services to establish a working party to develop an effective model of psychosocial support within a resource constrained environment, to improve the housing outcomes for people with a mental illness experiencing homelessness or at risk of homelessness, on discharge from Cowdy Ward.
- 2) That TEAM Health review its community housing program to ensure it meets the criteria of effective provision of housing and support to people with a mental illness in community housing.
- 3) That TEAM Health liaise with Top End Mental Health Services, the Top End Mental Health Consumer Organisation and the Association of Relatives and Friends of the Mentally Ill to develop a financial management information resource for consumers.

2. INTRODUCTION

This report details the findings of an action research project, the Housing Options for People with a Mental Illness (HOP). HOP was delivered by the Top End Association of Mental Health (TEAM Health) and funded by the Commonwealth Department of Family and Community Services (FaCS) through the National Homelessness Strategy. The project examined the impact of homelessness and related issues on people with a mental illness who were receiving treatment in the acute psychiatric inpatient unit (Cowdy Ward) of Royal Darwin Hospital. The project was supported by the knowledge and experience of representatives of organisations involved with program development and service delivery in mental health, psychiatric disability support, income support, housing, supported accommodation, welfare, family and community, indigenous and consumer services. The project also sought the views and experiences of consumers who had experienced homelessness during an acute episode of mental illness, to inform the research.

2.1 PROJECT OBJECTIVES

The objectives of HOP were:

- To provide practical support within a case management framework to clients with a mental illness who had been admitted to Cowdy Ward and who were homeless on admission or at risk of homelessness on discharge;
- To develop and document strategies which promoted positive outcomes for people at risk of homelessness who had a mental illness;
- To identify issues and undertake systems advocacy to raise awareness and promote change that would improve access to a range of services that supported people with a mental illness to secure and maintain stable housing;
- To promote collaboration between the Top End Mental Health Service (TEMHS), other relevant agencies and TEAM Health, to promote positive housing and housing related outcomes for people with a mental illness; and
- To document service delivery strategies and policy changes that had been trialled and to develop a good practice guide to inform future policy and practice at a national level.

2.2 KEY CONCEPTS

The definition of homelessness used in this report is in accordance with the definition adopted for the National Homelessness Strategy.

Homelessness is defined by three categories:

- **Primary homelessness** is experienced by people without conventional accommodation (eg sleeping rough, and in improvised dwellings);

- **Secondary homelessness** is experienced by people who frequently move from one temporary shelter to another (eg emergency accommodation, youth refuges, friends' places);
- **Tertiary homelessness** is experienced by people staying in accommodation that falls below minimum community standards (eg some boarding houses and caravan parks).

The definitions of the following mental health terms are based on those adopted by the National Mental Health Plan or the National Mental Health Report.

Acute Care Services provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short-term treatment.

Complex Conditions exist when a person experiences mental illness as well as other multiple and complex social, emotional and/or physical health problems. Complex conditions include mental illness with problematic substance abuse, histories of abuse, intellectual disability, and challenging, at risk, suicidal and criminal behaviours. People with complex conditions often have needs that require a co-ordinated response from multiple service sectors.

Discharge is defined as the process whereby a patient admitted to an acute psychiatric inpatient unit is released from the inpatient unit.

Forensic Mental Health Services provide assessment, treatment and care of mentally disordered individuals whose behaviour has led them to commit criminal offences or makes it likely that they will offend in the future if not adequately treated and contained.

Mental Illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities.

Mental Health Service is a network of specialised mental health service components within the general health system, coordinated across inpatient and community settings, to ensure continuity of care for consumers. The components can encompass assessment, crisis intervention, acute care, extended care, treatment, rehabilitation, specialised residential and housing support services and domiciliary care services. An integrated mental health service uses a case management system across all service components.

Psychiatric Disability is a consequence of mental illness; that is, the behavioural changes that can affect daily living, such as the ability to live independently, maintain employment or develop relationships. People who experience psychiatric disability as a result of their mental illness are the group most likely to experience difficulties with accessing and maintaining housing, employment, relationships and completing common daily

activities of living. The presence of a mental illness is not the determinant of need for support, rather the presence of a related psychiatric disability influences support needs. Not all people living with a mental illness will have a psychiatric disability that results in some level of functional impairment and social handicap. In addition, many people with a mental illness who need intensive support at some stage in their lives will develop the skills to effectively manage their illness and thus function independently with no specific supports.

Psychiatric Disability Support Service (PDSS) are not for profit, community managed organisations that provide community support services for people with a psychiatric disability as a result of their mental illness. Non-government organisations may promote self-help and provide support and advocacy services for consumers and carers or have a psychosocial rehabilitation role.

Separation is defined as the process whereby a patient of a mental health service ceases to be treated by the mental health service. This usually occurs at the end of an acute episode of mental illness.

Supported Accommodation Assistance Program (SAAP) is a joint Commonwealth and State/Territory program that provides transitional supported accommodation services to people who are homeless and assists them to achieve the maximum possible level of self reliance and independence.

2.3 METHODOLOGY

Action Research Questions

The HOP used an action research model to meet the project goals. Though the project was originally funded to research four key questions, the Reference Group recommended that these be developed into more specific questions, resulting in the project researching the following key questions:

- 1) What support do clients need to access and manage appropriate income or income entitlements?
- 2) What conditions need to be present for clients to maximise success in obtaining and maintaining appropriate housing?
- 3) What would it take for clients to successfully integrate into the community?
- 4) What is a reasonable case load for this client group and why?

Literature Review

To assist in addressing these research questions, a literature review was conducted by the project worker to identify known support strategies and conditions required to assist homeless people into stable housing and to gain a better understanding of the gaps in services or supports for these people in the Darwin region.

Identification of Clients for the Project

The project collected data from a random sample of people experiencing an acute episode of a mental illness who were inpatients of RDH from June 2002 to June 2003. People identified as homeless or at risk of homelessness were offered assistance by the project.

Surveys

Data was collected through surveys delivered as client interviews, file reviews and in focus groups.

Survey 1: The first survey was designed to elicit information about age, sex, marital status, dependant children, cultural identity, need for interpreter, income type, employment status, psychiatric diagnosis, use of alcohol and other drugs and support provided by family, friends and services. Data was also collected on pre-admission housing type, length of residency, satisfaction with housing, intention to return to this housing, whether an application had been made for public housing and, if the person was homeless whether they wanted assistance from the HOP. This survey was used by the project worker to gather information through interviews with patients in Cowdy Ward.

Survey 2: In consultation with the Reference Group, the first survey was modified slightly to be more culturally appropriate for Indigenous clients. It was also agreed that it would be more appropriate due to language barriers for the Aboriginal Mental Health Workers to gather the information. This survey was used by Aboriginal Mental Health Workers to gather information through interviews with Indigenous patients in Cowdy Ward.

Survey 3: The third survey collected data on age, diagnosis and client accommodation type upon discharge from Cowdy Ward. This survey was used by Aboriginal Mental Health Workers to gather data through review of client files of indigenous people discharged from Cowdy Ward.

Survey 4: The fourth survey was posted to clients who received active support from the HOP, and was designed to gauge client satisfaction with assistance provided by the HOP.

Survey 5: The fifth survey was delivered to focus group participants by the project worker, to elicit mental health consumers' views.

Clients Who Received Active Support From The HOP

The project worker offered active support to 34 people with a mental illness who were identified by the first and second surveys as being homeless prior to admission to Cowdy Ward. Of these 34 people, 26 accepted the offer of active support from the HOP.

Focus Group

Clients who had received active support from the HOP were also invited to attend a focus group meeting. The focus group aimed to provide mental health consumers with an opportunity to inform the action research by sharing their experiences and views about effective support strategies for people with a mental illness.

After consultation with the Reference Group, participants in the focus group received a \$30 payment for attending.

Reference Group

A Reference Group was established to support and guide the project. The Reference Group included stakeholders within the broader community and included representatives from:

- Aboriginal and Torres Strait Islander Commission (ATSIC);
- Anglicare;
- Centrelink;
- Commonwealth Department of Family and Community Services (FaCS);
- Northern Territory Department of Health and Community Services (DHCS);
- Northern Territory Shelter;
- Top End Association for Mental Health (TEAM Health);
- Top End Mental Health Services (TEMHS);
- Territory Housing;
- Top End Mental Health Consumers Organisation (TEMHCO).

The Reference Group played a consultative and advisory role for the HOP with specific terms of reference which included:

- Advising the project on relevant issues relating to the project;
- Providing feedback to the project from sector agencies regarding the project;
- Providing input into the Guidelines manual;
- Advocating agreed program and policy changes with respect to other related services;
- Participating in project planning;
- Participating in project evaluation through an informal project review each 2 months and formal review at 6 months and 12 months.

Project Information Session

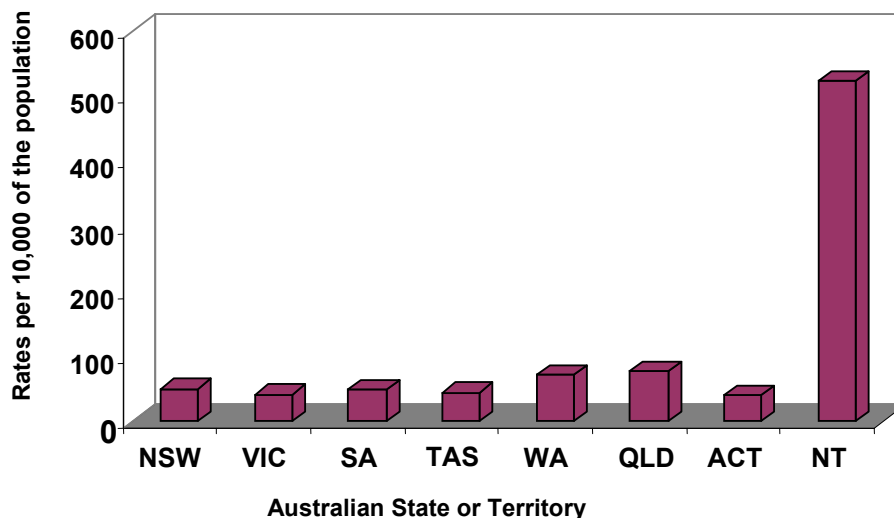
An information session about the aims and objectives of the HOP was held at Cowdy Ward when both morning and afternoon staff were on duty on the ward. A two-page summary outlining the HOP was developed and provided to staff with additional copies for staff not on duty and those who may be appointed during the course of the project.

3. CONTEXT AND BACKGROUND

3.1 HOMELESSNESS IN THE NORTHERN TERRITORY (NT)

As demonstrated in Figure 1, the NT has the highest incidence of homelessness in Australia, with homelessness rates over 10 times those recorded in other states (Chamberlain, 1996, p.4).

Figure 1: Incidence of Homelessness by State or Territory



3.2 HOMELESSNESS AND MENTAL ILLNESS

Obtaining and maintaining stable and appropriate accommodation is a crucial factor in the recovery of a person who has experienced a serious mental illness. Homelessness not only exacerbates the condition, but also contributes to a myriad of additional problems a person needs to deal with. Studies have shown that homelessness puts a person at greater risk of mental health relapse and readmission, suicide, substance abuse, physical health problems, social isolation, involvement in the criminal justice system, and higher mortality rates (Berry et al., 2003; Koegel and Burnam, 1988). On the other hand, successfully housing and supporting a person reduces hospital admissions, improves health and wellbeing, improves social contacts and relationships, and increases the likelihood of employment (Berry et al., 2003). Further, if a person's home environment is positive, it can provide a sense of security, safety, independence, and privacy (Department of Human Services, 2000). There is also evidence that the cost of providing services that help homeless mental health consumers to obtain and maintain housing is far outweighed by the net savings to the community in the areas mentioned above (Berry et al., 2003).

Mental illness is a strong predictor of homelessness, and homelessness precipitates and exacerbates mental health issues (Sussex, Moore, and Link, 1993). Studies in the US have shown that among the homeless, lifetime prevalence rates of major mental illness are five times the national average (Sussex et al., 1993). Similar results have been found in Australia where evidence suggests that rates of mental illness among the homeless may be as high as 70% (Herrman et al., 1990; Herrman, McGorry, Bennett, van Riel, and Singh, 1989). The symptoms of mental illness can lead to a range of behaviours that may make it more difficult for the sufferer to access and maintain stable housing. Depending on the disorder, people with a mental illness may experience periods of extreme paranoia, anxiety, depression, active hallucinations and a disruption of thought patterns. They may disturb neighbours, miss rent or other payments, or neglect to maintain the premises to the extent that they put their accommodation at risk (Lezak and Edgar, 1996). The symptoms of mental illness can also hamper a person's ability to perform routine tasks such as dressing, preparing a meal, or cleaning. Consumers are often socially isolated, having less access to support from family and friends to manage the challenges of daily life. Another characteristic of mental illness is its unpredictability. Symptoms may abate for a while, only to return at a time when formal supports are no longer available. For many people with a mental illness, stressful or unpredictable situations bring on a recurrence of disabling symptoms, which may increase vulnerability to homelessness.

While there are many studies on homelessness and mental illness, there appears to be little research focusing specifically on rates of homelessness among people who have been recently discharged from a psychiatric ward. A study in the US among adolescents found that within five years of discharge from a psychiatric ward, 33 percent experienced at least one episode of homelessness (Embry et al., 2000). However, rates of homelessness among discharged psychiatric ward patients in Australia are largely unknown.

3.3 HOMELESSNESS AND INDIGENOUS AUSTRALIANS

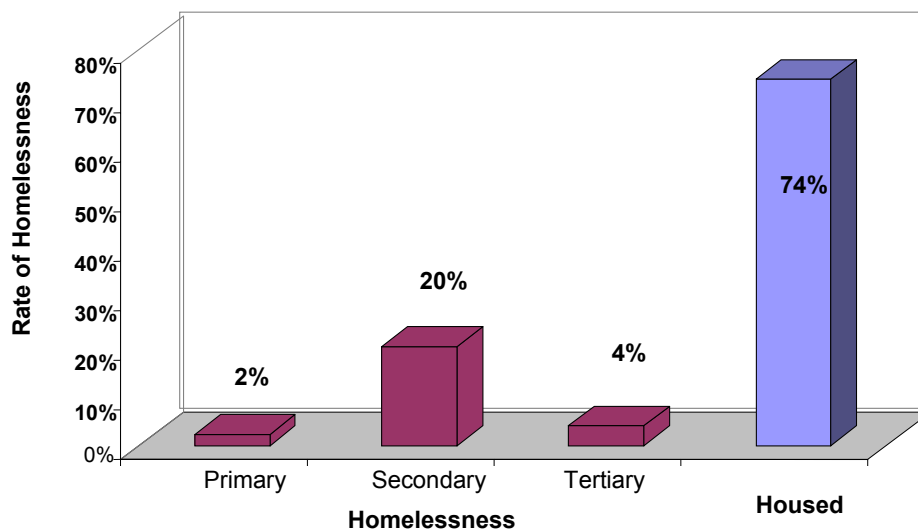
Indigenous Australians experience higher levels of homelessness and live in a poorer standard of housing than non-Indigenous Australians (Memmott and Fantin, 2001). Of all homeless people in Australia who sleep 'rough' or in an improvised dwelling, 50 percent are Indigenous. In the NT 90 percent of all people experiencing primary homelessness are Indigenous Australians, even though they constitute only 24 percent of the NT's population (Australian Bureau of Statistics, 2003; Chamberlain, 1996). Furthermore, Indigenous Australians are over-represented in the Supported Accommodation Assistance Program (SAAP) population, comprising 16 percent of the SAAP population nationally and 45 percent of the NT's SAAP clientele (SAAP National Data Collection, 2001).

4. FINDINGS

4.1 ESTIMATED HOMELESSNESS RATES OF PEOPLE ADMITTED TO COWDY WARD

TEMHS does not collate data on the level of homelessness of people on admission to Cowdy Ward. The project estimated the rate of homelessness of people admitted to Cowdy Ward in the following manner. During the year ending June 2003, 470 admissions or episodes of acute inpatient care were recorded for Cowdy Ward (DHCS, 2003b). However this admission data does not reflect the number of people who received care in Cowdy Ward, as it also includes readmissions. In other words any person who has two episodes of acute inpatient care in the same year will be recorded twice. At the time of interpreting data for this report, the readmission rate to Cowdy Ward for the year ending June 2003 had not been published. The project used the data from the previous year to estimate the number of readmissions to Cowdy Ward in the year ending June 2003, in an attempt to estimate the number of people who received care. During the year ending June 2002, 28 percent of all admissions were readmissions. The project has assumed that this trend continued in the year ending June 2003, and estimated that 126 episodes of care provided by Cowdy Ward were readmissions, and therefore estimated that 344 people were admitted to Cowdy Ward for treatment of their mental illness during the year ending June 2003.

Figure 2: Estimated Homelessness Rate of People with a Mental Illness on Admission to Cowdy Ward

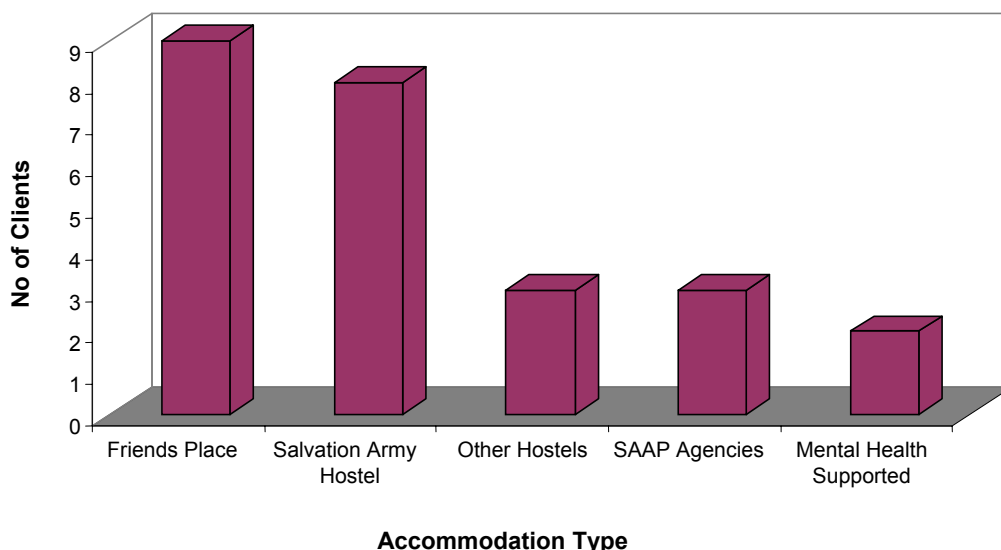


The project collected 127 completed surveys (Survey 1 and Survey 2). This represented an estimated 37 percent of all admissions to the ward during the year ending June 2003. However, only 3 surveys were completed with people who identified themselves as Indigenous Australians. A further examination of the data published by the DHCS, established that for the year ending June 2002, 41 percent of all admissions to the ward were people who identified themselves as Indigenous Australians (DHCS, 2003c). The project was unable to interview people who had already been discharged to establish their state of homelessness on admission to the ward. On the basis that evidence exists that Indigenous Australians experience higher

levels of homelessness than non-Indigenous Australians and that people with mental illness also experience high rates of homelessness, the project assumed that a 26 percent level of homelessness of people receiving mental health treatment in Cowdy Ward was a conservative estimate.

As it was estimated that at least 75 percent of people who were homeless on admission to Cowdy Ward experienced secondary homelessness, the project examined the type of accommodation these people had been residing in prior to admission. Figure 3 demonstrated that only 7 of the 27 people who experienced secondary homelessness were living in supported accommodation prior to admission to Cowdy Ward.

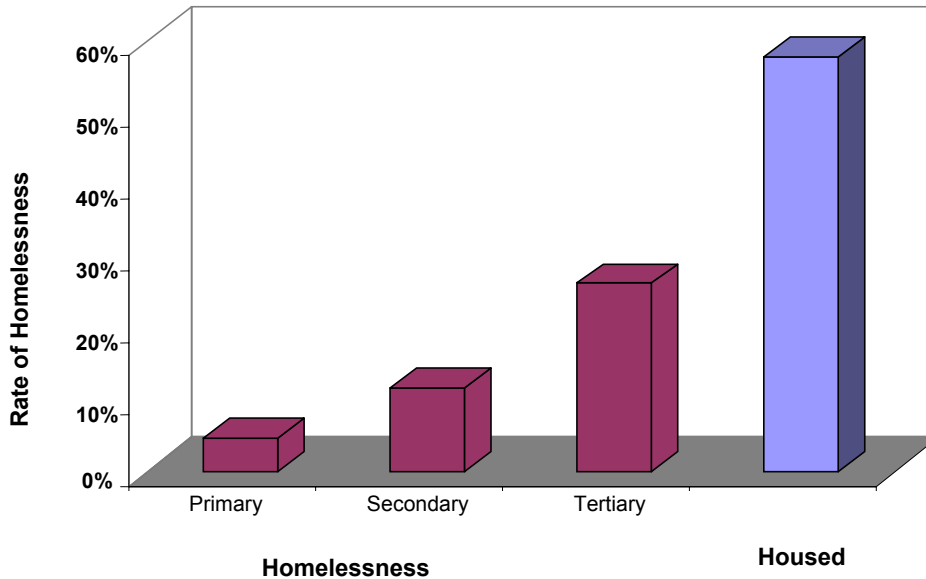
Figure 3: Accommodation Type Used by People Experiencing Secondary Homelessness



4.2 ESTIMATED HOMELESSNESS RATES OF INDIGENOUS PEOPLE ON DISCHARGE

TEMHS does not collect or collate data on the level of homelessness of people on discharge from Cowdy Ward. Aboriginal Mental Health Workers supported the project to collect data (Survey 3) on the level of homelessness of 130 Indigenous people upon discharge from Cowdy Ward. This sample represented 89 per cent of all Indigenous people who had been admitted to Cowdy Ward during the project time frame (Department of Health and Community Services, 2003b). It has been argued that overcrowding meets the criteria for tertiary homelessness (Memmott, Long and Chambers, 2003; Young, 1998). On this basis the project identified residing in a two or three bedroom house with between 7 to 20 other residents as tertiary homelessness. Indigenous people identified as being discharged into tertiary homelessness were living with an average of 12 other people and 5 of these households were reported to have 20 residents. As demonstrated in Figure 4, 42 percent of Indigenous people were discharged into homelessness.

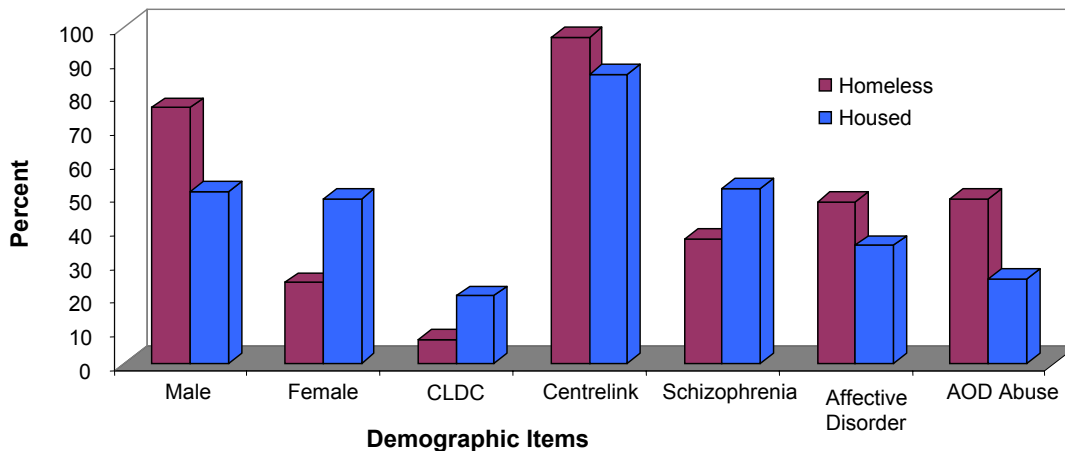
Figure 4: Rates of Homelessness of Indigenous People on Discharge



4.3 COMPARISON OF HOMELESS AND HOUSED PEOPLE SURVEYED

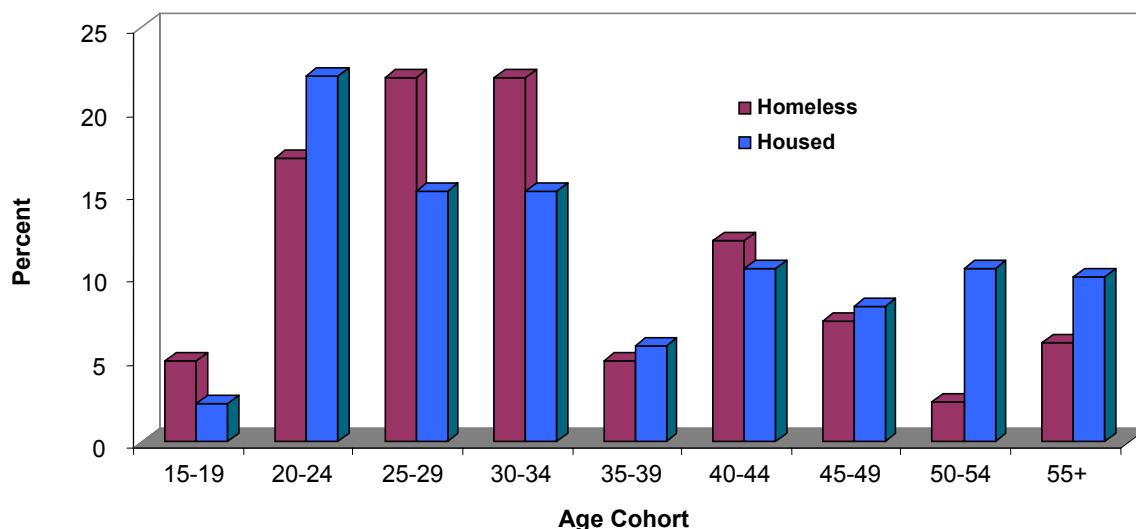
Of the 127 completed surveys undertaken with people in Cowdy Ward, 41 people were identified as either homeless on admission or at risk of homelessness on discharge. Figures 5 and 6 show the main characteristics of this group. This group was predominately male (76 percent), aged between 20 and 34 (61percent), with either a diagnosed affective disorder or schizophrenia and nearly 50 percent self reported alcohol or other drugs abuse which was twice the rate reported by the people who were housed. The majority of all clients were in receipt of Centrelink income support.

Figure 5: Demographic Profile of Housed and Homeless People Surveyed in Cowdy Ward



CLDC – Culturally and linguistically diverse community
 AOD – Alcohol and other drugs

Figure 6: Age Cohort, Comparison of People Housed & Homeless Surveyed in Cowdy Ward



4.4 ISSUES IDENTIFIED BY CONSUMERS ABOUT SUPPORT PROVIDED IN COWDY WARD

In July 2003, six male mental health consumers attended a focus group, facilitated by the project worker. These consumers reported on their views and experiences of their admission to Cowdy Ward, which were influenced by their personal experiences, their attitudes and their housing and support history. All participants had experienced at least one inpatient admission, were identified as homeless and consequently received support from the project. All participants raised a range of issues around income support and suitable housing. Two main themes emerged in their answers. One theme was that consumers felt they had received very little support from the staff of Cowdy Ward.

- 'The staff on the ward don't help ...no help what-so-ever.'
- 'You are forced into peer support in Cowdy, because you don't get any support.'

The second theme was that consumers expressed a need for psychosocial support around income accommodation, shopping and recreation.

- 'Someone to take care of my money, because I only think of today when I am sick, and I need someone to look after it.'
- 'Financial advisors...so we understand what is happening with our money.'
- 'Drive me to look at accommodation.'
- 'Someone to write down on a bit of paper what your options are.'
- 'Filling in forms.'
- 'A mini van to take people out of the ward to Casuarina, Centrelink, the library, shopping to show where bus stops are.'

- ‘Someone to do store visits regularly to buy smokes and toiletries. If nurses are too busy – doesn’t happen.’
- ‘Help you with day-to-day needs.’

These consumers also expressed views about wanting the psychosocial support service to be delivered at a set time by a devoted, flexible, trained person who is externally employed.

- ‘Flexible person with a sense of humour. Someone trained for the job, who knows how to handle people [who are unwell].’
- ‘Not nurses because they are power hungry.’
- ‘Someone who is outside the hospital...otherwise it defeats the purpose.’
- ‘Someone who is devoted.’

4.5 DIRECT SUPPORT SERVICES PROVIDED TO CLIENTS BY THE PROJECT

Identification of Clients Experiencing Homelessness Who Required Support

The Reference Group established that due to the project being time limited and required to undertake action research as well as direct client support, the project caseload should be limited to around 25. As it was difficult to estimate the amount of time in hours that was required to support individual clients, the Reference Group also determined that project support should not exceed 50 percent of the project workers time.

People admitted to Cowdy Ward who participated in Survey 1 or 2 and identified as homeless or at risk of homelessness on discharge, were offered support to find and maintain stable housing. Of the 34 people identified, 26 agreed to assistance from the project and of this group, 3 identified as Indigenous Australians. Three full-time Aboriginal Mental Health Workers provided a support service for Indigenous patients and this is believed to have impacted on the level of participation by Indigenous people in the HOP.

Project Support to Clients Experiencing Homelessness

‘One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable, and secure accommodation. Living with a mental illness – or recovering from it – is difficult even in the best of circumstances. Without a decent place to live it is virtually impossible.’ (Burdekin, 1993, p. 37)

The project provided varying levels of direct assistance depending on clients’ needs and capacity to obtain and maintain suitable housing. As demonstrated in Table 1, the project made an average of 12.7 contacts with each client. The actual time spent assisting individual clients ranged from 2 to 20 hours. Contact hours

included the initial consultation on the ward, helping the client complete housing and income forms, correspondence, referrals to and contact with other services.

Table 1: Summary of Project Contacts with Clients

CONTACT TYPE	NUMBER OF CONTACTS	AVERAGE NUMBER CONTACTS / CLIENT
Direct contact with client	130	5.4
Phone contact with client	62	2.6
Email to other services or Carer	78	3.3
Phone contact with other services or Carer	47	2.0
Fax contact with other services or Carer	5	0.2
Other	8	0.3
TOTAL CONTACTS	330	12.7

The project also assisted with transport to access services such as SAAP agencies, Territory Housing, Centrelink, agencies that provided emergency relief funding, assistance to purchase whitegoods, household items and food, connecting utilities, setting up direct payments from bank accounts and any further follow-up support as needed. It is important to note, that the project was not the only support being provided to these clients. Support for these clients was provided collaboratively by TEMHS case managers and TEAM Health outreach, transitional supported accommodation and community aged care services, which were required to successfully maintain these clients in the community. The following case studies highlight the different levels of support required to maintain two clients of the project.

CASE STUDY A

'Paul', 48 years old, single, unemployed with a diagnosis of depression was admitted to Cowdy Ward. Paul had no income, was sleeping on the beach and had no family or other social supports in Darwin. He had no possessions except the clothes he was wearing when admitted. Paul reported walking out of a two-bedroom rented unit during an acute episode of his mental illness. Paul had also destroyed his personal documents and had no form of identification.

Paul became a client of HOP eight days after admission to Cowdy Ward. A referral was made to Centrelink and a social worker visited Paul at the ward a few days later. Paul was assisted to obtain copies of his birth certificate and other identification documents and to complete an application for Newstart. As Paul was incapacitated due to his mental illness, he was eligible to income support from the date of his medical certificate. This provided Paul with a much needed, accumulated back payment from Centrelink

Paul was assisted by the project to view accommodation options, meet with prospective landlords, to complete tenancy forms and purchase household items and food. Due to his Centrelink entitlement Paul had sufficient income to pay his bond and rent in advance as required. Paul moved into a private rental granny flat on discharge from the ward. Paul was allocated a TEMHS Case Manager and no longer needed assistance from the HOP.

CASE STUDY B

'Harry' a 65 year old, single man of a culturally and linguistically diverse background had a diagnosis of schizophrenia. Harry had lived in psychiatric disability supported accommodation interstate for many years prior to his recent arrival in Darwin. Harry spent two nights in a backpacker's hostel before he came to the attention of TEMHS. Harry was voluntarily admitted to Cowdy Ward.

As Harry required support with his activities of daily living, he was referred to supported accommodation and psychosocial rehabilitation services. Harry was also referred to the Aged Care Assessment Team for assessment for eligibility for a Community Aged Care Package (CACP). Harry was eligible and able to access a CACP. With this level of support, Harry's level of functioning improved and he moved into independent living in a shared two-bedroom unit. In the 10 months, in addition to supported accommodation, Harry had received 12 hours support from the project, 150 hours of support through skills training from the rehabilitation program and 271 hours support from his CACP.

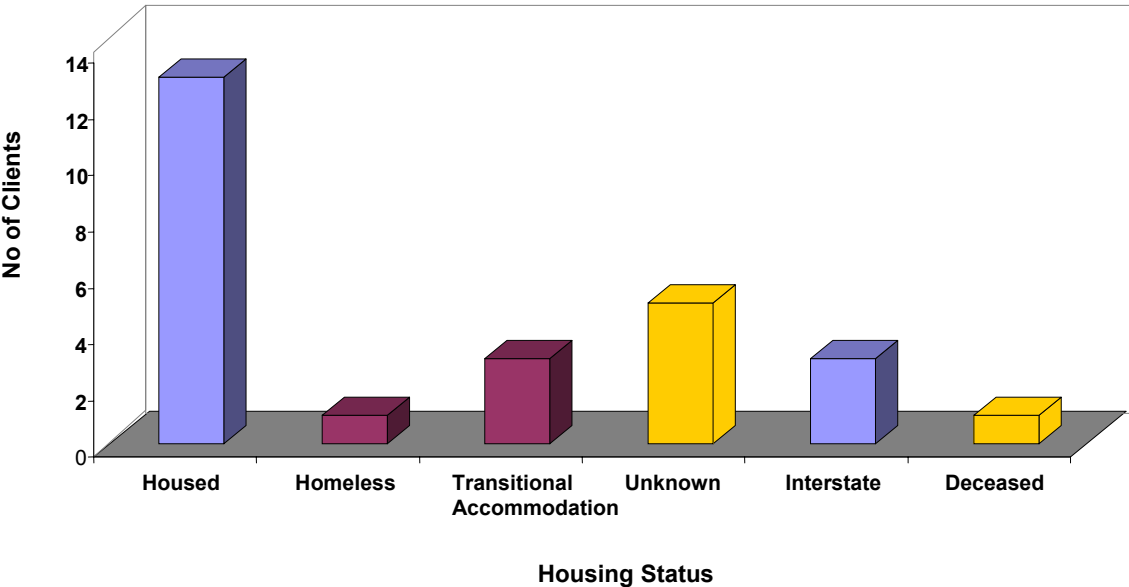
After 10 months, Harry became unwell, developed symptoms of paranoia and believed that his neighbours wanted to kill him. Harry was readmitted to Cowdy Ward for 11 days, but refused to return to his unit on discharge, reporting that his neighbours were too noisy. Harry accepted supported accommodation and stayed two nights. Harry moved to a homeless men's shelter. Harry was persuaded to lodge an application for housing in a unit within a Territory Housing Seniors Village. Harry remained homeless.

These two case studies demonstrate that a person's capacity to remain in housing is determined by a complex interplay of psychological, social and environmental factors. Harry's support needs were high and he was able to access a high level of support. However he was able to maintain stable housing for only 10 months. By contrast Paul required only seven hours of assistance from the project to obtain private housing, and at the time of completion of the project was still housed and receiving no formal supports or services. This complexity of need is characteristic of clients with mental illnesses and has implications for service development and delivery, such as flexible service options and the determination of case loads.

At the end of June 2003, three months prior to the completion of the project, the project ceased providing direct support to clients. Clients who required ongoing support were assisted by other TEAM Health support services. Of the 26 people who were homeless, 13 had stable housing in Darwin and 3 had stable housing interstate. Four people remained homeless, 1 person was residing in a SAAP agency waiting for a vacancy

in shared TEAM Health Community Housing. The remaining three were residing in mental health specific, transitional supported accommodation as they required ongoing daily support. There were 5 people the project was unable to contact. Prior to these clients relocating, they had all resided in accommodation that was defined as secondary homelessness. One person assisted by the project committed suicide. Figure 7 summarises the housing status of HOP clients at the end of June 2003.

Figure 7: Housing Status Of HOP Clients At The End Of June 2003



Client Satisfaction With The HOP

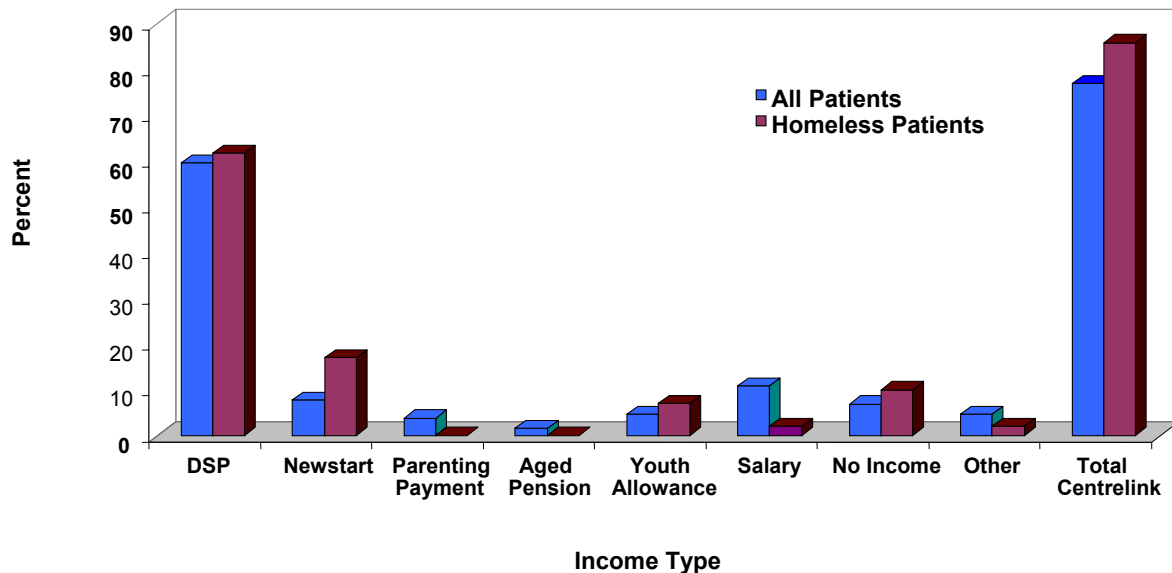
People who had received a service from the project were posted a copy of Survey 4, which contained 3 questions to gauge client satisfaction with the service provided. Clients were asked whether they were satisfied overall with the support they received from the project, whether they received enough support from the project, and whether they received effective support from the project. Clients were asked to measure satisfaction by circling a number on a scale from 1 to 10, 1 recorded a poor level of satisfaction and 10 recorded the highest level of satisfaction. Eight surveys were returned and the results were collated. Overall clients recorded a high level of satisfaction with the service provided by the project. On reflection, it is likely that a larger sample of client satisfaction surveys would have been achieved if the survey had been delivered at the time clients were separated from the service.

4.6 STRATEGIES, ADVOCACY AND COLLABORATION TO PROMOTE POSITIVE OUTCOMES

What support do clients need to access and manage appropriate income or income entitlements?

Of the consumers identified by HOP as homeless or at risk of homelessness, 78 percent were dependent on Centrelink for income support, and a further 7 percent had no income. It was obvious that Centrelink had a very important role with people experiencing an acute episode of mental illness. Figure 8 summarises income type of clients.

Figure 8: Income Type of All Patients Surveyed In Cowdy Ward



Issues were raised in the focus group about consumers' lack of access to income when admitted to Cowdy Ward and they reported their sense of helplessness in this situation.

I didn't have any money. No access to money, and I couldn't do anything about it because I didn't have money for a phone call.'

Consumer talking about his experience in Cowdy Ward

Though consumers in Cowdy Ward needed assistance with a range of income support issues, the research revealed that there was no systematic identification of consumers income support needs by the ward. Consumers required assistance with:

- Applications for Centrelink entitlements;
- Notifications of change in circumstances to Centrelink;
- Understanding and meeting Centrelink responsibilities, obtaining crisis exclusions and crisis payments;

- Completing Centrelink forms and bond assistance applications;
- Accessing emergency relief funding.

Consumers also reported that, even with regular income, they needed assistance with:

- Meeting the Centrelink mutual obligation requirements;
- Transport to attend Centrelink appointments to maintain income support;
- Budgeting;
- Establishment of direct debits and Centrepay transactions for rent, utilities and debts.

The HOP addressed these issues by two main strategies - direct client support work (detailed in section 4.5 of this report) and the promotion of a collaborative relationship between Centrelink and Cowdy Ward.

On behalf of clients, the HOP advocated with a local Centrelink Customer Service Centre. As a result of this, Centrelink provided an on-site service as required to clients identified by Ward staff. It became evident that a regular service was required and Centrelink established a weekly visit. This provided a regular opportunity for people receiving treatment in Cowdy Ward:

- With no income, to access Centrelink income support;
- To provide Centrelink with information about their change in circumstances;
- To have their existing payment types and obligations reviewed;
- To be assessed for eligibility for crisis payments.

Centrelink provided the ward with a direct phone number for advising them of the admission of a patient who would benefit from a visit with a Centrelink representative. Once implemented, the Centrelink social workers attended the ward within two to four days of being advised, and provided valuable assistance to homeless people on the ward. Within a short time frame Centrelink had established a regular weekly service in Cowdy Ward.

What conditions need to be present for clients to maximise success in obtaining and maintaining housing?

The literature indicates that there are a range of conditions that must be present if people with mental illness are to obtain and maintain housing. These conditions can be grouped into three primary categories – choice, accessibility and availability of support.

Mental health consumers on low incomes have limited affordable housing choices, discrimination is common and many find it difficult to compete in the private rental market (FaCS, 2001). Many consumers report that they do not disclose their illness to landlords when applying for a lease due to fear of discrimination or fear of their name being entered in a tenancy database. Anti-discrimination laws seek to prohibit the use of non-

commercial factors in choosing tenants and thus promote efficiency and equity in accommodation supply (Johnston, 2003). Anti-discrimination laws have had some success in changing behaviour and attitudes, but Johnston (2003) argues that many consumers still experience the discrimination that the law seeks to prohibit and consumers are prone not to complain or seek redress for unfair trading.

Another factor influencing consumers' capacity to choose their accommodation are the tenancy databases, nationwide computerised records of tenants with debt or property damage issues which can be accessed for a fee. Landlords who want information about potential tenants can access the database. The exchange of information about 'bad' tenants through access to a tenancy database can be viewed as a simple strategy to address potential risk (Johnston, 2003). However, the databases lack transparency, accountability, and any means of meaningful redress for wronged consumers. This results in exclusion and discrimination by private landlords. Other areas of concern include inaccurate or trivial listings, the use of threats to list tenants, refusal to remove a listing or the non-disclosure of listings, unfair or poor operating procedures for databases, charging tenants to access information about their listing, breaches of privacy, and the lack of an effective dispute resolution procedure (Residential Tenancies Authority, 2002). Another problem identified was that people are unable to access accommodation because of a listing on the database, whether the listing is accurate or not. The Office of the Federal Privacy Commissioner and State and Territory residential tenancy tribunals have received numerous complaints about tenancy databases (Attorney-General for Australia, 2003). In their present form these databases have the potential to discriminate against mental health consumers and may inadvertently place consumers at risk of homelessness.

Housing accessibility, like choice, is another important factor in the acquisition and maintenance of housing. One of the strongest measures of housing accessibility is the availability of public housing. There are extensive waiting lists for public housing in Darwin. At the time of writing Darwin's public housing authority (Territory Housing) had the following waiting periods: 1 bedroom – 30 months, 2 bedroom – 6 months, 3 bedroom – 4 months.

There is also insufficient psychiatric-specific independent-living accommodation (community housing). Darwin has 21 community housing beds for consumers. The occupancy rate for the six months to the end of December 2002 for this accommodation option was 92 percent (TEAM Health, 2003). There is frequently a waiting list for these beds. Any vacancy is usually as a result of not being able to find a suitable applicant to share a two-bedroom unit with an existing tenant. This service is funded by TEAM Health and tenants' contributions.

A system which impacts on accessibility is Centrelink's Centrepay service. Centrepay provides tenants with the ability to have their rent automatically deducted from their income support and paid directly to landlords. Consumers who have recently been discharged from a psychiatric ward frequently experience cognitive impairment due to their illness, medication or from the stress of having their lives disrupted by a hospital

admission. Non payment of rent is a frequent and direct cause of homelessness for clients with mental illness. Direct payment of rent via the Centrepay system can be a crucial safeguard against homelessness. The project officer worked collaboratively with the NT Centrepay Manager to raise awareness of the Centrepay system with real estate agents and private landlords. In June 2002 only 5 of Darwin's real estate agents were registered with Centrepay. Very few private landlords were registered. The project worker found that many real estate agents and private landlords were resistant to using the Centrepay system, for two reasons. Firstly, the \$1.01 charge deducted from each payment is a barrier for some landlords. Some private landlords at the lower end of the rental market were reluctant to pay the charge. Cheaper properties are more likely to be used by clients with mental illness who have a limited income. For real estate agents the charge caused difficulties with trust account reconciliation. Real estate agents explained that they need to make a manual entry to the accounts to cover the \$1.01 for all the Centrepay payments received for that day, and that this caused significant administrative problems. Real estate agents suggested they be billed monthly for the charge rather than have it deducted from each payment. However, Centrelink presently is not able to provide this option. Secondly, for some real estate agents, their unique tenant code number does not appear on their trust account statement if the payment comes from Centrepay whereas it will with a BPay payment, over the counter payment, or encoded bank deposit slip. Again, the project worker has been advised by Centrelink that this is currently administratively not possible.

Despite these barriers, active promotion of the Centrepay scheme by the NT Centrepay Manager and the project worker over the past 12 months has been very successful. At the time of writing 41 Darwin real estate agents and private landlords have registered with Centrepay. Almost all SAAP agencies and hostel/crisis accommodation services are also registered (Zander, 2003). Clearly, this scheme can be successful if marketed sufficiently, and can be an important factor in reducing homelessness among consumers.

The third major issue affecting clients' capacity to obtain and maintain accommodation is the level of support able to be provided. For clients with a psychiatric disability who require daily support, there is insufficient psychiatric disability supported accommodation in Darwin. This housing is designed for those not well enough to live independently or who have skill deficits. Darwin has one long-term, and one short-term supported accommodation facility totalling 10 beds. Occupancy rates for these 10 beds for the six months to the end of December 2002 were 100 percent and 96 percent respectively (TEAM Health, 2003). Of the 10 beds, only five are long-term supported accommodation. Due to the high demand on beds in Cowdy Ward (2001-2002 occupancy rate of 90 percent - Department of Health and Community Services, 2003a), there is high demand for beds and pressure to discharge patients. Moreover, chronically unwell patients often have admission periods that stretch into months. Yet there is no non-acute facility for those who continue to require high levels of support, or sufficient long-term supported accommodation beds for those chronically unwell. 'Some form of long-term institutional care must be retained for the small proportion of people whose psychiatric disability is so severe that they will not be able to live in the community.' (Burdekin 1993, p. 913)

What would it take for clients to successfully integrate into the community?

“There are huge costs involved in not providing additional, and more effectively coordinated housing and support services. Many people with a mental illness are revolving through justice, health and SAAP systems, at a very high cost to governments, and at a major cost to the person’s own wellbeing and future life options.” (National Mental Health Working Group, 2003)

The National Mental Health Standards state that the mental health service ‘....provides consumers with access to a range of treatment and support programs which maximise the consumer’s quality of community living.’ (Department of Health and Family Services, 1997). A study by Rasanen et al (2000), which examined the support needs of 253 discharged psychiatric inpatients, found only 15 percent did not require formal ongoing support, and that this was frequently due to lack of any family or social supports.

Consumers who are homeless or at risk of homelessness are often isolated socially, with little or no access to family and community supports (FaCS, 2003). Psychiatric Disability Support Services, increasing access to community support services and positive informal social support will help reduce the risk of homelessness for mental health consumers.

The link between maintaining stable housing and the various forms, levels and sources of support is conceptually very broad (O’Brien, Inglis, Herbert, and Reynolds, 2002). The support may have a direct association with maintaining a home, such as practical assistance with paying rent, activities of daily living, budgeting, accessing income and household tasks, or with more intangible factors that can improve a person’s mental health and emotional wellbeing, and are indirectly associated with maintaining stable housing. O’Brien et al (2002) suggests that, as well as the practical housing support outlined above, that to reintegrate into the community consumers will also need support with:

- Social and community connectedness;
- Stable and supportive environments;
- Social and physical activities;
- Access to social and supportive relationships;
- Physical security;
- Opportunity for self-determination and control over one’s life;
- Leisure and recreation activities;
- Employment and work (full time or part time, paid or voluntary, supported employment) and vocational training opportunities in appropriate community settings and facilities;
- Participation in further or continuing education;

- Mental health treatments that maximise opportunities for the consumer to live independently in their own accommodation.

This research demonstrates that the ability to sustain stable housing is dependent on the satisfaction of client needs across all spheres of life. 'The balance is critical – my wellness is contingent on a few things staying in place' (cited by O'Brien et al, 2002). Support helps a person to cope with the day to day demands of life generally, resulting in a greater likelihood of people being able to sustain housing (O'Brien et al, 2002).

Consumer feedback into the HOP and O'Brien et al's (2002) research, provide the following list of the most important support consumers have received in the past, or believe is important, to maintain stable housing:

- Cleaning;
- Budgeting;
- Shopping;
- Transport;
- Medication information and prompts;
- Education about mental illness;
- Social structure and structured activities;
- Someone to talk: counselling, peer groups, social groups;
- Vocational issues: preparing a resume, job interview techniques;
- Getting to medical appointments – reminders;
- Coping with illness/symptoms;
- Help with AOD misuse;
- Legal issues;
- Family conflict;
- Help accessing courses such as art, vocational, computer, first aid.

Surveys of consumers show they consider the attributes of a 'good' support worker, or good support, to include (O'Brien et al, 2002):

- A good understanding of mental illness;
- Being a good listener;
- Accessible and flexible support - the ability to accommodate unpredictable changes in capacity and needs associated with mental illness;
- Consistency of support;
- Time to nurture a good relationship;
- A person who 'gives me positive feelings about myself;'
- A person who cares;

- A person, consumers can engage in meaningful activities with.

The vast majority of homeless patients in a psychiatric ward will require assistance to find and maintain stable housing. Homeless consumers are frequently socially isolated, and are not able to draw on the support from family and friends that the general community may have open to them. Housing support takes various forms including factors that may on the surface not seem to be directly related to housing issues.

According to FaCS (2001), to enable people experiencing or at risk of homelessness to participate in the social and economic life of the community, the community should consider the following:

- Increasing community development activities that encourage and enable people to share in community life;
- Providing resources to facilitate access to community supports, and reducing barriers to access
- Providing advocacy services;
- Making community support program providers more aware of homelessness;
- Providing information in accessible formats;
- The provision of 'drop-in' facilities for leisure and recreation as well as opportunities for homeless people to participate in leisure and recreation activities individually and/or in groups.

Family and social support networks are another source of support to clients. Homeless consumers, or people at risk of homelessness, can often be identified by their restricted access to and lack of participation in family and social life. Research suggests that consumers with a serious mental illness have on average only four or five people in their 'social network', compared with 20 to 30 people for the general population, and that smaller social networks are associated with greater use of inpatient facilities (Goldberg, Rollins and Lehman, 2003). Family and social networks contribute to self-esteem and wellbeing in good times, and provide support and protection when times are bad (Commonwealth of Australia, 2001). It is important to remember that homeless people are frequently estranged or isolated from these networks. A critical factor in achieving good outcomes for consumers can be obtained by facilitating and sustaining these important support networks.

There are many barriers consumers face in accessing support. Using the support services mentioned above generally means making and attending an appointment, observing standard office hours and being prepared to wait. A degree of planning and stability is required to do these things. Consumers who are homeless or at risk of homelessness may have no fixed address, little money and limited access to childcare and transport and may find it difficult to make and keep appointments.

Clients of the project reported that 'Just because I don't ring up for support, doesn't mean I don't need it' (Consumer, 2003). Consumers often cannot afford a phone on their limited income, and if they can it will

often be an incoming calls only service. When asked to identify the circumstances preceding their admission to hospital consumers describe a cycle of feeling unwell and needing to talk to someone but having no phone to call for support and no money to catch a bus or a taxi to the community mental health facility to get help. For example one respondent described 'just sitting in the flat alone freaking out' because he could not access support (Consumer quote, 2003). The end result for many consumers is they become increasingly unwell and have no supports to turn to, resulting in an admission to hospital. Consumers say they may not have had to go to hospital if more support and better access to support were available.

Consumers may also have difficulty meeting the paperwork requirements of some agencies. They may not have birth certificates, bank statements, referral letters, ATM cards, driver's license or any other form of photo identification. Mail may not reach them because they have no fixed address. Unless support agencies are prepared to be flexible, the people who most need their services will be denied access to them.

The Personal Support Program (PSP) is funded by the Department of Family and Community Services and helps people who find it difficult to be involved in the workforce or the community. Participants may face homelessness, drug and alcohol problems, psychological disorders, domestic violence, financial management problems or long-term unemployment. PSP endeavours to bridge short-term crisis assistance and employment-related assistance (Department of Employment and Workplace Relations, 2003).

The project provided information about PSP to clients who expressed an interest in returning to work. Though the project had advised some people and several clients had been interviewed by Centrelink social workers, when asked on Survey 4 if people knew about the Centrelink Personal Support Program, only 1 person responded yes, and that person was on the PSP waiting list. Centrelink informed the project that people in receipt of a Disability Support Pension (DSP) would not be referred to the PSP because there is no requirement for them to re-enter the workforce. However, people with a mental illness in receipt of Newstart would be referred to the PSP.

It is clear that the PSP program is aimed at people on Newstart who have a requirement to look for work. The reality for people receiving a pension is they are given low priority by the PSP. As such, the PSP program in its current format provides little support to homeless people exiting a psychiatric ward.

What is a reasonable caseload for a person supporting homeless consumers, and why?

A review of the literature on mental health caseloads suggests 30 as a maximum. Though, research suggests a manageable caseload for this population is between 11 and 19 (Meldrum and Yellowless, 2000). This question was put to the reference group for the Housing Options Project and there was general agreement that a definitive figure could not be provided. The group discussed the difficulty in making a recommendation for a reasonable caseload figure and concluded that a number of factors influence the size of a caseload. They include:

- Would the case manager give priority to the most needy? In that case a workable case load may be only 10 people with high needs;
- Case loads will vary depending on individual client needs at any given time;
- The skills of the worker will influence the size of a workable case load;
- Attempts to devise case loads by 'scaling' a person's needs (1-4) have not been successful;
- How quickly a client's health and functioning improves will affect caseloads. The change in clients' health and functioning will vary depending on the population type a person is working with.

5. RECOMMENDATIONS

As a result of the research it is recommended that:

- 1) TEAM Health liaise with Top End Mental Health Services to establish a working party to develop an effective model of psychosocial support within a resource constrained environment, to improve the housing outcomes for people with a mental illness experiencing homelessness or at risk of homelessness, on discharge from Cowdy Ward.
- 2) TEAM Health review its community housing program to ensure it meets the criteria of effective provision of housing and support to people with a mental illness in community housing.
- 3) TEAM Health liaise with Top End Mental Health Services, the Top End Mental Health Consumer Organisation and the Association of Relatives and Friends of the Mentally Ill to develop a financial management information resource for consumers.

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